STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495377	A. BUILDING _____ B. WING _____	R 10/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF CHARLOTTESVILLE	1165 PEPSI PLACE CHARLOTTESVILLE, VA 22901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS An unannounced Medicare/Medicaid revisit to the standard survey conducted 08/23/16 through 08/25/16, was conducted 10/18/16 through 10/20/16. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. Uncorrected deficiencies are identified within this report. Corrected deficiencies are identified on the CMS 2567-B. No complaints were investigated during the survey. The census in this 120 certified bed facility was 113 at the time of the survey. The survey sample consisted of 17 current Resident reviews (Residents 101 through 117).	{F 000}		
{F 157} SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident	{F 157}		11/23/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 11/02/2016

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{F 157}	Continued From page 1 and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to notify the physician of a change in treatment for one of 17 residents in the survey sample. Resident #103's physician was not notified or consulted for a change in treatment when an open sacral/coccyx pressure ulcer was assessed as healed. The findings include: Resident #103 was admitted to the facility on 5/17/16 with a re-admission on 7/14/16. Diagnoses for Resident #103 included heart disease, high blood pressure, difficulty swallowing, arthritis and chronic kidney disease. The minimum data set (MDS) dated 7/28/16 assessed Resident #103 as cognitively intact. Resident #103's clinical record documented the resident was assessed on 8/25/16 with an open wound on his sacrum measuring 1.5 cm x 1 cm x .1 cm (length by width by depth in centimeters). The record documented a physician's order dated 8/25/16 for wound cleanser, stoma powder and	{F 157}	The Laurels of Charlottesville wishes to have this submitted plan of correction stand as its allegation of compliance. Our date of alleged compliance is November 23, 2016. Preparation and/or execution of this plan of correction does not constitute admission to, nor agreement with, either the existence of or the scope and severity of any of the cited deficiencies, or conclusions set forth in the statement of deficiencies. This plan is prepared and/or executed to ensure continuing compliance with regulatory requirements. Resident #103□s physician was notified of current skin condition and treatment orders. Current residents with skin conditions have the potential to be affected by this practice.	

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{F 157}	Continued From page 2 protective cream each day for treatment of the wound. A pressure ulcer tracking form listed weekly assessments of the sacral wound starting on 8/31/16. On 9/2/16 the sacral/coccyx area was assessed as a stage II pressure sore. The tracking form documented additional assessments of Resident #3's coccyx pressure sore on 9/12/16, 9/13/16, 9/20/16 and 9/27/16. The form listed the wound as "Resolved" on 9/29/16. There was no notification to the physician and/or nurse practitioner regarding the healed status of the resident's sacral/coccyx pressure ulcer. Nursing notes made no mention the wound was healed. Treatment records from 10/1/16 through 10/18/16 documented continued daily treatments to the sacral/coccyx area with the wound cleanser, stoma powder and protective cream. Treatment records documented treatment to the area three times per day instead of the ordered once per day treatment. On 10/19/16 at 10:10 a.m. the licensed practical nurse (LPN #1) routinely caring for Resident #103 was interviewed about any notification to the physician regarding healing of the wound. LPN #1 stated the order for wound treatment was not changed on 9/29/16 when the pressure ulcer was marked as resolved. LPN #1 stated, "I wanted to keep the treatment for protection." LPN #1 stated even though the open wound had healed the resident's skin remained sensitive in that area. When asked if the physician was notified or consulted about what type of treatment was needed after the wound was healed, LPN #1 stated, "No." LPN #1 stated she kept the previous orders (cleanser, stoma powder, protective cream) in place until yesterday	{F 157}	DON/designee will educate current licensed nursing staff on communicating change in condition/treatments to physicians and/or resident□s legal representative. Unit Managers/designees will review treatment orders, to include admission orders, 5 times per week for 4 weeks to ensure physician and/or legal representative notification has been made. Variances will be corrected as identified and continued education provided. DON will report audit results to the QA Committee for further review. Continued compliance will be monitored through the facility□s quality assurance program. Additional education and monitoring will be initiated for any identified concerns. Completion Date: November 23, 2016	

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{F 157}	Continued From page 3 (10/18/16). When asked why the physician was not notified or consulted, LPN #1 stated, "I didn't want to get rid of the treatment. I felt he needed something for protection." Resident #103's plan of care (revised 9/5/16) listed the resident had the potential for skin impairment. Interventions listed to maintain intact skin included, "Conduct weekly head to toe skin assessments, document and report abnormal findings to physician." The National Pressure Ulcer Advisory Panel (NPUAP) Quick Reference Guide on page 12 defines a pressure ulcer as a "localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear." This reference defines a stage II pressure ulcer as, "Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough..." (1) These findings were reviewed with the administrator and director of nursing during a meeting on 10/19/16 at 3:15 p.m. (1) National Pressure Ulcer Advisory Panel, European Pressure Ulcer Advisory Panel and Pan Pacific Pressure Injury Alliance. Prevention and Treatment of Pressure Ulcer: Quick Reference Guide. Emily Haesler (Ed.). Cambridge Media: Osborne Park, Western Australia; 2014.	{F 157}		
F 276 SS=D	483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS A facility must assess a resident using the quarterly review instrument specified by the State	F 276		11/23/16

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F 276	Continued From page 4 and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure a quarterly MDS (minimum data set) assessment was completed every 3 months, as required for one of 17 residents in the survey sample (Resident # 102). The facility failed to complete a quarterly MDS assessment within the 3 month time frame for Resident # 102. Findings include: Resident # 102 was admitted to the facility originally on 04/13/11. Diagnoses for Resident # 102 included, but were not limited to: weakness, dementia, history of falls, atrial fibrillation, Parkinson's disease and dysphagia. The most recent completed MDS assessment was a quarterly assessment with an Assessment Reference Date (ARD) of 07/01/16. This MDS assessed the resident with a cognitive score of "4", indicating the resident had severe impairment in daily decision making skills. The resident was additionally assessed as requiring extensive assistance from at least one staff for all ADL's (activities of daily living). During Resident # 102's clinical record review, the resident's MDS section was reviewed. A quarterly MDS assessment with an ARD of 07/01/16 (as described above) was completed	F 276	Resident #102□s MDS assessment with an ARD of 9/26/16 has been completed and submitted. The annual MDS assessment dated 10/21/16 has been changed to an ARD of 12/10/16. Current residents residing at The Laurels of Charlottesville have the potential to be affected. The Regional Clinical Resource Specialist will in-service MDS staff on completing MDS assessments timely per the RAI manual guidelines. The MDS Coordinator/ designee will audit 10% of current MDS□s for 4 weeks to ensure timely completion. Any variances will be corrected and continued education will be provided. The DON will report the results of the audits to the QA Committee for review. Continued compliance will be monitored through the facility□s quality assurance program. Additional education and monitoring will be initiated for any identified concerns. Completion Date: November 23, 2016.	

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F 276	Continued From page 5	F 276		

and submitted. A quarterly MDS with an ARD of 09/26/16, listed as active (not complete/nor submitted) was reviewed, additionally an annual assessment was started and dated 10/21/16 listed as active (not completed/nor submitted) was also reviewed.

On 10/19/16 at approximately 2:10 p.m., the DON (director of nursing) was asked to speak to the MDS coordinator. RN (Registered Nurse) # 2 was present and stated that she was the clinical resource nurse and was currently acting as the MDS person.

RN # 2 was asked, what the time frame for completion of quarterly MDS assessments were. RN # 2 stated, "92 days." The RN was made aware of Resident # 102's MDS assessments and was asked why the resident's MDS quarterly assessment dated 09/26/16 was not completed.

RN #2 stated that the facility lost their entire MDS staff on 09/15/16 and that she has been left to do them and that is why it was not completed.

According to the Long-Term Care Facility RAI (Resident Assessment Instrument) User's Manual Version 3.0 (Chapter 2), effective 10/01/2010, the quarterly assessments are: "...The quarterly assessment is an OBRA non-comprehensive assessment for a resident that must be completed at least every 92 days following the previous OBRA assessment of any type...The ARD (A2300) must be not more than 92 days after the ARD of the most recent OBRA assessment of any type..."

The DON and administrator were informed in a meeting with the survey team on 10/19/16 at

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F 276	Continued From page 6 approximately 3:15 p.m. No further information and or documentation was presented prior to the exit conference on 10/20/16 at 9:30 a.m.	F 276		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to follow professional standards of nursing practice for one of 17 residents in the survey sample. Resident #103, assessed as having a pressure sore, had no documented assessment of the wound. The findings include: Resident #103 was admitted to the facility on 5/17/16 with a re-admission on 7/14/16. Diagnoses for Resident #103 included heart disease, high blood pressure, difficulty swallowing, arthritis and chronic kidney disease. The minimum data set (MDS) dated 7/28/16 assessed Resident #103 as cognitively intact. Resident #103's clinical record documented the resident was assessed on 8/25/16 with an open wound on his sacrum measuring 1.5 cm x 1 cm x .1 cm (length by width by depth in centimeters). The record documented a physician's order dated 8/25/16 for wound cleanser, stoma powder and protective cream each day for treatment of the wound. A pressure ulcer tracking form listed	F 281	Resident #103 has received a head to toe skin assessment and documentation accurately reflects current skin integrity. Current residents residing at The Laurels of Charlottesville have the potential to be affected. Unit Managers/designees will review skin assessments completed by licensed nursing staff five times per week for 4 weeks to ensure 100% of current residents are receiving skin assessments timely. Any variances will be corrected as identified and education will be provided. The ADON/designee will in-service current licensed nursing staff on completing skin assessments per facility policy to ensure early identification and treatment of skin variances. The DON will report audit results to the QA Committee. Continued compliance will be monitored	11/23/16

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F 281	Continued From page 7 weekly assessments of a sacral/coccyx wound starting on 8/31/16. On 9/2/16 the coccyx area was assessed as a stage II pressure sore. The tracking form documented additional assessments of Resident #3's coccyx pressure sore on 9/12/16, 9/13/16, 9/20/16 and 9/27/16. The form listed the wound as "Resolved" on 9/29/16. Weekly skin assessments for October 2016 were reviewed. The assessment dated 10/14/16 listed the resident's skin as "intact." The weekly assessment dated 10/12/16 listed the resident had an existing pressure ulcer. The location of the pressure sore was marked on the body diagram on the upper right buttock. The clinical record documented no assessment of the wound. There was no description of the stage, size, skin color, presence of odor or drainage. Nursing notes made no mention of the wound. The next weekly skin assessment sheet dated 10/17/16 listed the resident's skin as intact. On 10/19/16 at 10:00 a.m. with the resident's permission and accompanied by the licensed practical nurse (LPN) #1, Resident #103's sacral area was observed. The resident had a small area of excoriated skin with several pinhole sized open areas scattered over his sacral area. LPN #1 applied fingertip pressure to discolored skin surrounding the excoriation. The discolored skin blanched when touched. There were no other open areas noted on the buttocks, coccyx or sacral area. On 10/19/16 at 10:10 a.m. LPN #1 was interviewed about the assessment of 10/12/16 of a pressure ulcer. LPN #1 stated the resident previously had a stage II pressure sore on his	F 281	through the facility□s quality assurance program. Additional education and monitoring will be initiated for any identified concerns. Completion Date: November 23, 2016.	

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F 281	Continued From page 8	F 281		

coccyx but that wound was healed as of 9/29/16. LPN #1 stated registered nurse (RN) #3 performed the skin assessment on 10/12/16. LPN #1 stated there was no assessment documented regarding the 10/12/16 wound marked on the weekly skin sheet. LPN #1 stated the resident's skin prior to the 10/12/16 assessment was intact. LPN #1 stated if the resident had a pressure sore on 10/12/16 it should have been marked as a new area and a pressure ulcer tracking record initiated. LPN #1 stated concerning the 10/12/16 assessment, "She (RN #3) didn't write a note."

Resident #103's plan of care (revised 9/5/16) listed the resident had the potential for skin impairment. Interventions listed to maintain intact skin included, "Conduct weekly head to toe skin assessments, document and report abnormal findings to physician."

The facility's policy titled Weekly Skin Assessment (revised 6/11) documented, "The condition of the skin or the presence of new skin impairment is to be assessed and documented weekly on the Weekly Skin Assessment..." Procedures listed for the skin assessment included, "...The licensed nurse is to complete a head to toe skin observation weekly for each guest...If there are no areas of skin impairment place a checkmark in the box 'skin intact'... If there is an existing wound condition or pressure ulcer that has been previously identified, check the box 'Has existing (circle) wound condition/pressure ulcer'. Then circle wound condition or pressure ulcer... Identify each new pressure ulcer on the body image (s) with an 'x'... Place a check mark in the box 'Has new pressure ulcer - indicate with x and see Pressure Ulcer

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Record'... Assess and measure area... Initiate Pressure Ulcer Record... Identify any new wound or skin condition on the body image (s) with an 'o'... Place a check mark in the box 'Has new wound condition - indicate with o and see Wound and Skin Record... Add new pressure ulcer records and/or wound and skin records in treatment book... File completed form in the Medical Record." (sic)

The National Pressure Ulcer Advisory Panel (NPUAP) Quick Reference Guide on page 12 defines a pressure ulcer as a "localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear." Page 35 of this reference states concerning assessment of pressure ulcers, "Document the results of all wound assessments... Assess and documented physical characteristics including: location, Category/Stage, size, tissue type(s), color, periwound condition, wound edges, sinus tracts, undermining, tunneling, exudate, and odor..." This reference on page 12 defines a stage II pressure ulcer as, "Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough..." (1)

The Lippincott Manual of Nursing Practice 10th edition on page 16 states concerning standards of nursing care, "A deviation from the protocol should be documented in the patient's chart with clear, concise statements of the nurses' decisions, actions, and reasons for the care provided, including any apparent deviation. This should be done at the time the care is rendered because passage of time may lead to a less than accurate recollection of the specific events... Legal claims most commonly made against

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F 281	Continued From page 10 professional nurses include the following departures from appropriate care: failure to assess the patient properly or in a timely fashion, follow physician orders, follow appropriate nursing measures, communicate information about the patient, adhere to facility policy or procedure, document appropriate information in the medical record..." (2) These findings were reviewed with the administrator and director of nursing during a meeting on 10/19/16 at 3:15 p.m. (1) National Pressure Ulcer Advisory Panel, European Pressure Ulcer Advisory Panel and Pan Pacific Pressure Injury Alliance. Prevention and Treatment of Pressure Ulcer: Quick Reference Guide. Emily Haesler (Ed.). Cambridge Media: Osborne Park, Western Australia; 2014. (2) Nettina, Sandra M. Lippincott Manual of Nursing Practice. Philadelphia: Wolters Kluwer Health/Lippincott Williams & Wilkins, 2014.	F 281		
{F 309} SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical	{F 309}	Resident #103□s medical record reflects	11/23/16

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{F 309}	Continued From page 11 record review, the facility staff failed to follow physicians order for three of 17 residents in the survey sample. Physician prescribed treatments for Resident #103's open pressure ulcer were continued for 18 days after the wound was assessed as healed. Resident #110 did not have TED support hose in use as ordered by the physician. Resident #114 was administered the medication Mucinex for 8 days when the medication was ordered to be given for only 3 days. The findings include: 1. Physician ordered treatments for Resident #103's stage II pressure ulcer were continued for 18 days after the wound was assessed as healed. Resident #103 was admitted to the facility on 5/17/16 with a re-admission on 7/14/16. Diagnoses for Resident #103 included heart disease, high blood pressure, difficulty swallowing, arthritis and chronic kidney disease. The minimum data set (MDS) dated 7/28/16 assessed Resident #103 as cognitively intact. Resident #103's clinical record documented the resident was assessed on 8/25/16 with an open wound on his sacrum measuring 1.5 cm x 1 cm x .1 cm (length by width by depth in centimeters). The record documented a physician's order dated 8/25/16 for wound cleanser, stoma powder and protective cream each day for treatment of the wound. A pressure ulcer tracking form listed weekly assessments of a sacral/coccyx wound	{F 309}	current skin condition and treatment. Resident #110□s TED hose are being applied per physician orders. Resident #114 no longer receives Mucinex. No harm resulted to these residents from reported concerns. Current residents residing at The Laurels of Charlottesville have the potential to be affected by these practices. Unit Managers/designees will review wound/skin documentation weekly for 4 weeks to ensure physician orders are followed and documentation is complete to include measurements, notifications, care plans, and treatments. Unit Managers/designees will conduct daily rounds five times per week for 4 weeks to ensure devices are applied per physician orders to current residents. Administrative Nursing team will conduct medication pass observations three times per week for 4 weeks on all shifts. Variances will be corrected at the time of observation. Additional education will be initiated as indicated. The ADON/designee will in-service current licensed nurses on the five rights of medication administration and documentation, following physician□s orders, and physician notification of	

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{F 309}	Continued From page 12 starting on 8/31/16. On 9/2/16 the coccyx area was assessed as a stage II pressure sore. The tracking form documented additional assessments of Resident #3's coccyx pressure sore on 9/12/16, 9/13/16, 9/20/16 and 9/27/16. The form listed the wound as "Resolved" on 9/29/16. There was no notification to the physician and/or nurse practitioner regarding the healed status of the resident's sacral/coccyx wound. Previously prescribed treatments for the open area continued for 18 consecutive days after the wound was assessed as healed on 9/29/16. Resident #103's treatment record documented continued daily treatments to the sacral/coccyx area with the wound cleanser, stoma powder and protective cream from 10/1/16 through 10/18/16. The treatments were done three times per day instead of once per day as ordered. On 10/19/16 at 10:00 a.m. with the resident's permission and accompanied by the licensed practical nurse (LPN) #1, Resident #103's sacral area was observed. The resident had a small area of excoriated skin with several pinhole sized open areas scattered over his sacral area. LPN #1 applied fingertip pressure to discolored skin surrounding the excoriation. The discolored skin blanched when touched. There were no other open areas noted on the buttocks, coccyx or sacral area. On 10/19/16 at 10:10 a.m. the licensed practical nurse (LPN #1) routinely caring for Resident #103 was interviewed about the continued treatment to the sacral/coccyx area after the area was healed. LPN #1 stated the order for wound treatment was not changed on 9/29/16 when the pressure ulcer	{F 309}	changes in condition. The DON will report audit findings to the QA Committee for review. Continued education will be provided as indicated. Continued compliance will be monitored through the facility□s quality assurance program. Additional education and monitoring will be initiated for any identified concerns. Completion Date: November 23, 2016.	

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was marked as resolved. LPN #1 stated, "I wanted to keep the treatment for protection." LPN #1 stated even though the open wound had healed the resident's skin remained sensitive in that area. When asked if the physician or nurse practitioner were notified or consulted about what type of treatment was needed after the wound was healed, LPN #1 stated, "No." LPN #1 stated she kept the previous orders (cleanser, stoma powder, protective cream) in place until yesterday (10/18/16). When asked why the physician was not notified or consulted, LPN #1 stated, "I didn't want to get rid of the treatment. I felt he needed something for protection."

On 10/20/16 at 8:00 a.m. the director of nursing (DON) was interviewed about why the continued treatments to Resident #103's coccyx area were done three times per day when they were ordered once per day. The DON stated when the original order was entered into the computer the frequency was entered wrong. The DON stated the treatments were ordered to be done once per day. The DON stated the physician or nurse practitioner should have been consulted about a change in treatment after the wound was assessed as healed.

The National Pressure Ulcer Advisory Panel (NPUAP) Quick Reference Guide on page 12 defines a pressure ulcer as a "localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear." This reference defines a stage II pressure ulcer as, "Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough..." (1)

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These findings were reviewed with the administrator and director of nursing during a meeting on 10/19/16 at 3:15 p.m.

(1) National Pressure Ulcer Advisory Panel, European Pressure Ulcer Advisory Panel and Pan Pacific Pressure Injury Alliance. Prevention and Treatment of Pressure Ulcer: Quick Reference Guide. Emily Haesler (Ed.). Cambridge Media: Osborne Park, Western Australia; 2014.

2. Resident #110 did not have physician ordered TED hose (compression stockings) in place.

Resident # 110 was admitted to the facility originally on 10/10/16. Diagnoses for Resident #110 included: Foot wound, right foot inflammation, peripheral arterial disease, diabetes, and neuropathy (inflammation of the nerves).

The most current full MDS (minimum data set) was an initial assessment dated 09/19/16. Resident #110 was assessed as being cognitively intact with a score of 15 of 15.

Resident # 110's physician's orders were reviewed on 10/18/16 and revealed an order dated 10/10/16 that read "TED STOCKINGS BELOW KNEE left leg apply in a.m. remove hs [hours of sleep...]"

Resident #110's care plan was then reviewed and revealed a care plan titled "Potential for impaired skin integrity [...]" An intervention read "TED hose as ordered."

On 10/18/16 at 4:15 a.m. Resident #110 was

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{F 309}	Continued From page 15 observed laying in bed. This surveyor entered Resident #110's room and conversed with Resident #110. During the conversation, this surveyor observed Resident #110 without the TED hose in place and asked Resident #110 about wearing TED hose. Resident #110 verbalized that the staff had not put the TED hose on in over a week. On 10/18/16 at 4:45 p.m. the nurse who was assigned to Resident #110 was interviewed (license practical nurse, LPN #4). LPN #4 verbalized that she (LPN #4) had laid Resident #4 down earlier and was going to apply the TED hose, but had gotten busy and did not do it. The above finding was brought to the attention of the director of nursing (DON) and the administrator on 10/19/16 at 3:15 p.m. No other information was presented prior to exit conference on 10/20/16. 3. The facility failed to discontinue Mucinex ER (extended release) for Resident # 114 as ordered by the physician, as a result the resident received the medication for 5 additional days. Findings include: Resident # 114 was admitted to the facility originally on 7/9/15. Diagnoses for Resident #114 included: depression, obesity, diabetes, muscle weakness, chronic pain, and COPD (chronic obstructive pulmonary disease).	{F 309}		

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The most current full MDS (minimum data set) was a significant change dated 7/13/16. Resident #114 was assessed as being cognitively intact with a score of 15 of 15.

During a medication pass and pour observation on 10/19/16 at approximately 8:20 a.m., LPN (Licensed Practical Nurse) # 2 stated that she was going to change an order in the computer to match the medication that was on hand for Resident # 114. The LPN had Mucinex ER 600 mg tablets (stock box) on hand and the MAR (medication administration record) documented that the resident was to receive one 1200 mg tab every 12 hours. The LPN then stated that the medication had been completed and the resident was not to receive it. LPN # 2 did not administer the medication.

A medication reconciliation was completed for Resident # 114. The resident's current physician's orders dated October 2016, were reviewed and documented, "...[start 10-11-16] Mucinex ER 1200 mg tablet one tab every 12 hours (8:00 am, 8:00 pm) po [by mouth] every 12 hrs [hours] x [times] 3 days...."

The resident's MAR was then reviewed. The MAR documented the Mucinex ER 1200 mg tablet one tab every 12 hours; oral upper respiratory infection...Extended directions: ...X 3 days...."

The MAR revealed that the medication was started on 10/11/16, as ordered and continued for 5 additional days, after the medication should have been discontinued (10/13/16).

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{F 309}	Continued From page 17 A policy was obtained from the DON (director of nursing) titled, "Medication Administration." The policy documented, "...All medications and treatments shall be initiated, administered, and/or discontinued in accordance with written physician's orders..." The DON (director of nursing), the ADON (assistant director of nursing) and the administrator were made aware in a meeting with the survey team on 10/20/16 at approximately 9:10 a.m. The ADON stated that she noticed it when this surveyor had asked for copies of the physician's orders and MARs for Resident # 114. No further information or documentation was presented prior to the exit conference on 10/20/16 at 9:30 a.m. to evidence why Resident # 114's Mucinex ER was not discontinued as ordered by the physician.	{F 309}		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on a medication pass and pour observation, staff interview and clinical record review the facility staff failed to ensure a medication error rate of less than 5 % (percent), the facility's medication error was 5.5%. There were 36 opportunities and two errors. The facility staff failed to ensure a medication	F 332	Resident #112 and Resident #114 received no harm from this concern. Physician□s orders were changed during the survey. Current residents residing at The Laurels of Charlottesville have the potential to be affected by this practice.	11/23/16

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F 332	Continued From page 18 error rate of less than 5%. Finding include: During a medication pass and pour observation on 10/19/16 at approximately 7:55 a.m., LPN (Licensed Practical Nurse) # 2 prepared medications for Resident # 112. LPN # 2 dispensed one EC (enteric coated) Aspirin 325 mg (milligrams) from a stock bottle for Resident # 112. LPN # 2 prepared the EC Aspirin, in addition to other medications and administered the medications to the resident. At approximately 8:20 a.m., LPN # 2 prepared medications for Resident # 114. LPN # 2 prepared medications from a pharmacy dispensed medication bag for Resident # 114. LPN # 2 opened the medication bag and removed one tablet (Sertraline 50 mg) and placed in the dispensing cup. This medication was given with a Bumex 1 mg tablet and a Sevelamer Carbonate 800 mg tablet; a total of 3 pills in the dispensing cup. A medication reconciliation was completed on Resident # 112 at approximately 10:15 a.m. Resident # 112's current POS (physician's order set) dated 10/01/16 through 10/31/16 was reviewed and documented, "...Aspirin 325 mg One tab oral once per day (8:00 am)...noted on 05/26/16...LPN # 2..." The physician's order was for regular Aspirin, not EC Aspirin as administered by LPN # 2. A medication reconciliation was completed on Resident # 114 at approximately 10:30 a.m. Resident # 114's current POS (physician's order	F 332	Administrative Nursing team will conduct medication pass observations three times per week for 4 weeks on all shifts. Variances will be corrected at the time of observation. Additional education will be initiated as indicated. The DON will report findings to the QA Committee for review. The ADON/designee will in-service current licensed nurses on the five rights of medication administration and documentation and following physician□s orders. Continued compliance will be monitored through the facility□s quality assurance program. Additional education and monitoring will be initiated for any identified concerns. Completion Date: November 23, 2016.	

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set) dated October 2016 was reviewed and documented, "...Sertraline HCL 50 mg tablet One tab oral once per day (8:00 am) give with 100 mg to equal 150 mg...noted on 09/07/16...LPN # 2..."

Additionally there was an order for Resident # 114, that documented: "...Sertraline HCL 100 mg tablet One tab oral once per day (10:00 am) give w/50mg for a total of 150 mg...noted on 09/07/16...by LPN # 2..."

LPN # 2 was interviewed on 10/19/16 at approximately 2:20 p.m. and stated that Resident # 112 used to get EC aspirin before and she (LPN)didn't realize the order had changed from EC to regular aspirin. The LPN stated that she did not read the entire order on the MAR. The LPN additionally stated that, this (EC Aspirin) is what she has been giving the resident.

LPN # 2 was then interviewed regarding Resident # 114. Resident # 114's physician's orders and MARS (medication administration records) were reviewed with LPN # 2 and confirmed that the physician's order was to give the Sertraline 50 mg and 100 mg together, not separate. The LPN stated that she did not know why this happened, but she had been giving the medication separately (since September), but stated that she changed the order this morning for the medications to be given together, after the med pass observation. The LPN was informed that the medication was not administered per physician's order (to be given together) and was asked why the order was not clarified before. The LPN stated that the resident normally gets her medications at 10:00 and that she did not read the order completely. The Sertraline 50 mg was administered at 8:21 a.m. and the Sertraline

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F 332	Continued From page 20 100 mg was documented as administered at 10:00 a.m. A policy was obtained from the DON (director of nursing) titled, "Medication Administration." The policy documented, "...All medications and treatments shall be initiated, administered, and/or discontinued in accordance with written physician's orders..." No further information or documentation was presented prior to the exit conference on 10/20/16 at 9:30 a.m.	F 332		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.	F 425		11/23/16

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F 425	Continued From page 21 This REQUIREMENT is not met as evidenced by: Based on a medication pass and pour observation, resident interview, staff interview and clinical record review, the facility staff failed to ensure pain medication for one of 17 residents (Resident # 115) was available for administration. The facility staff failed to ensure Resident # 115 had physician ordered pain medication available for administration. Findings include: Resident # 115 was admitted to the facility on 10/14/16. Admission diagnoses for the resident included, but were not limited to: spinal cord injury, spondyloslisthesis (a spinal disorder in which a bone (vertebra) slips forward onto the bone below it) with surgical repair, pain, and muscle weakness. The resident did not have any current MDS (minimum data set) assessment information available. The resident's clinical record documented that the resident was assessed on admission as being cognitively intact and as requiring moderate assistance from one staff for hygiene, dressing, toileting and ambulation. During a medication pass and pour observation with LPN (Licensed Practical Nurse) # 3 at 8:30 a.m., the LPN stated that Resident # 115 had complained of pain and she (LPN) was going to administer a pain medication to the resident. The LPN stated that the resident complained of pain in her back and rated the pain a 6 out of 10, on the pain scale.	F 425	Resident #115□s pain medication was received during survey and administered to the resident to ensure pain control. There was no harm to Resident #115 regarding this concern. Current residents receiving pain medication have the potential to be affected by this practice. Administrative nursing team will audit medication carts 3x/week for 4 weeks to ensure availability of pain medication. Any occurrence of missing pain medication will be reported to pharmacy so medication can be obtained and reported to physician so alternative pain medication can be offered if indicated. Education will be provided to individuals as indicated. The results of the audits will be reported to the DON who will report findings to the quality assurance team for review. Additional education will be provided as indicated. The ADON/designee will in-service current licensed nurses on ensuring the facility is providing pharmaceutical services per physician orders. Continued compliance will be monitored through the facility□s quality assurance program. Additional education and monitoring will be initiated for any identified concerns. Completion Date: November 23, 2016.	

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LPN # 3 opened the resident's MAR (medication administration record) on the computer and looked for the pain medication. The LPN then opened the narcotic drawer on the medication cart and looked for the medication to administer Resident # 115. The LPN stated that the resident has an order in the computer for Norco 5-325 mg (milligrams), but could not find the medication in the cart.

LPN # 2 then went to the nurses' station and looked at the resident's chart and found a hard copy prescription for the Norco 5-325 mg. The LPN then called the pharmacy, voiced that the resident needed pain medication and then faxed the prescription to the pharmacy.

LPN # 2 informed Resident # 115 that it would be a few minutes and that she would bring the medication when it was available for administration.

LPN # 2 continued with the medication pass and pour.

During the remainder of the medication pass and pour observation, LPN # 2 went to the nurses' station several times to call the pharmacy to retrieve a code in order to remove the medication from the locked computerized medication dispensing system. The pharmacy informed the LPN that a code could not be given without the facility faxing a request form first to the pharmacy. LPN # 2 stated that she did had not done that before (pharmacy normally gives a code over the phone) and did not have a form and did not know which form to use. The LPN asked the pharmacy to fax the facility a form to use to retrieve a code for Resident # 115.

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At 9:10 a.m., the LPN received the form from the pharmacy and filled it out and then faxed it back to the pharmacy.

At 9:20 a.m., Resident # 115 was observed with therapy staff coming down the hall and was on her way back to her room. The therapy staff spoke with LPN # 2 and stated that the resident needed her pain medication.

LPN # 2 went into the resident's room and again told the resident that the medication was on the way. LPN # 2 left the room.

Resident # 115 was interviewed while sitting on the side of her bed and was asked about her pain. The resident stated that she was in pain and hurting and did not know if she would be able to finish therapy. The resident stated that the staff normally give her the pain medication prior to therapy and she wasn't sure what the problem was today.

At 9:27 a.m., the LPN went back to the fax machine to check on the fax.

At 10:03 a.m., the LPN had obtained a code to retrieve the medication from the locked machine. The LPN put in the code and looked for the medication to pulled and the medication was not there or showing as available to pulled from the machine. The LPN tried several times and attempted several different areas to look for the medication in the computerized dispensing system.

The LPN called the pharmacy again and pharmacy informed the LPN to sign out and log

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THE LAURELS OF CHARLOTTESVILLE	1165 PEPSI PLACE CHARLOTTESVILLE, VA 22901

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F 425	Continued From page 24	F 425		

back in and sometimes it may take a few minutes for the medication to show up.

The LPN went back to the machine at 10:11 a.m., and again attempted several times to get the pain medication. The medication was not available for administration/dispensing.

The LPN then stated that she would offer the resident Tylenol, until the other medication arrives.

LPN # 3 went to the resident's room and informed the resident that the medication had not arrived and asked the resident if she could offer her Tylenol, the resident state, "Yes, you can."

The resident then stated that her pain was now a "7", where as before it was a 6 and further stated that she was still in pain. The resident stated that she did end up finishing her therapy and that the therapy actually helped with the pain.

The resident was administered Tylenol 650 mg at 10:21 a.m.

The resident was administered two Norco 5-325 mg tablets at 12:12 p.m.

Resident # 115's initial care plan was reviewed and documented, "...Pain history of arthritis, observe for pain and report as indicated...administer pain medications as ordered...eliminate or reduce causative factors...Back incision will have no signs or symptoms of infection for 90 days...dressing as ordered..."

A policy was obtained from the DON (director of

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F 425	Continued From page 25 nursing) titled, "Medication Administration." The policy documented, "...All medications and treatments shall be initiated, administered, and/or discontinued in accordance with written physician's orders..." The DON (director of nursing) and the administrator were made aware in a meeting with the survey team on 10/19/16 at approximately 3:15 p.m. No explanation was given as to why Resident # 115 did not have the prescription pain medication available for administration. No further information or documentation was presented prior to the exit conference on 10/20/16 at 9:30 a.m.	F 425		
{F 514} SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, the facility	{F 514}	Resident #114 received no harm regarding this concern and was receiving	11/23/16

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{F 514}	Continued From page 26 failed to ensure a complete and accurate clinical record for one of 17 Resident's, Resident #114. Resident #114's treatment record was not initialed to indicate that treatments had been performed 15 times in a period of 18 days. The Findings Include: Resident # 114 was admitted to the facility originally on 7/9/15. Diagnoses for Resident #114 included: depression, obesity, and diabetes. The most current full MDS (minimum data set) was a significant change dated 7/13/16. Resident #114 was assessed as being cognitively intact with a score of 15 of 15. On 10/19/16 Resident #114's physician orders were reviewed and revealed an active order for "Triad Wound Dressing Paste" to be applied three times a day and "Voltaren 1% Gel" to be applied twice daily. Review of Resident #114's treatment administration record (TAR) for a period of 10/1/16 through 10/18/16 revealed that the Triad paste had not been initialed as being applied on the following dates: 10/3/16, 10/4/16, 10/5/16, 10/6/16, 10/10/16, 10/11/16, 10/12/16, and 10/18/16, totaling eight times that the treatment was not initialed as being completed. Resident #114's TAR also revealed Voltaren Gel had not been initialed as being completed on the following dates:	{F 514}	treatment to affected area. Current residents receiving treatments have the potential to be affected by this practice. The DON/designee will in service current licensed nursing staff on professional standards of quality and the 5 rights of medication/treatment administration. The DON/designee will educate current licensed nursing staff on completing documentation in resident record. Unit managers/designees will audit medication /treatment administration records five times per week for 4 weeks to ensure completion of MAR/TAR signage. Any variances will be either corrected or the physician will be notified of treatment omissions to ensure quality of care. Additional staff education will occur for variances. The results of the audits will be reviewed in the monthly Quality Assurance meeting with additional monitoring provided as indicated. Continued compliance will be monitored through routine record reviews and through the facility□s quality assurance program. Completion Date: November 23, 2016.	

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{F 514}	Continued From page 27	{F 514}		

10/3/16, 10/5/16, 10/6/16, 10/10/16, 10/11/16, 10/12/16, and 10/18/16, totaling seven times that the treatment was not initialed as being completed.

On 10/19/16 at 1:30 p.m. the above finding was brought to the attention of the unit manager (registered nurse, RN #1) where Resident #114 resides. RN #1 reviewed Resident #114's TAR and verbalized that the nurses should be initialing the treatments as they do them, the nurses have the capability of pulling up any missed medications or treatments on the computer during their shift to ensure all treatments and medications are initialed and done. RN #1 verbalized that without documentation it would be hard to tell if Resident #114 actually received the treatment or if the nurses just failed to document that the treatment was performed.

On 10/19/16 at 2:00 p.m. Resident #114 was interviewed regarding treatments. Resident #114 verbalized that the nurses had been doing the treatments and could not recall if any treatments had not been done.

On 10/19/16 at 3:15 p.m. the above finding was brought to the attention of the director of nursing and administrator. The DON was asked for a policy regarding documentation of treatment and medications.

On 10/20/16 at 7:40 a.m. the DON presented a policy titled "Medication Administration" and read in part "Initial the guest's Medication Administration Record (MAR) immediately following administration." At this time the DON was asked if the policy was the same for treatment administration, the DON verbalized yes

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{F 514}	Continued From page 28 and went onto verbalized that we (facility staff) has some work to do regarding documenting on the MAR's and TAR's. No other information was presented prior to exit conference regarding the above finding on 10/20/16.	{F 514}		